111TH CONGRESS
1ST SESSION

S. 93

To provide quality, affordable health insurance for small employers and individuals.

IN THE SENATE OF THE UNITED STATES

JANUARY 6, 2009

Mr. BROWN introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To provide quality, affordable health insurance for small employers and individuals.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Business Empowerment Act''.

SEC. 2. DEFINITIONS.

(a) IN GENERAL.—In this Act, the terms ''health benefits plan'', ''carrier'', and ''dependent'' have the meanings given such terms in section 8901 of title 5, United States Code.

(b) OTHER TERMS.—In this Act:

(1) ADMINISTRATOR.—The term ''Administrator'' means the entity that enters into the contract under section 3(b).

(2) COMMISSION.—The term ''Commission'' means the National Health Coverage Commission established under section 8.

(3) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)). Such term shall not include an employee of the Federal Government.

(4) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers who employed an average of at least 1 but not more than 100 employees on business days during the year preceding the date of application. Such term shall not include the Federal Government.

(5) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' has the meaning given such term in section 2791(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(2)), except that

such term shall include the sponsor of a group health plan.

(6) OFFICE.—The term ''Office'' means the Office of Personnel Management.

(7) PARTICIPATING EMPLOYER.—The term ''participating employer'' means an employer that—

(A) elects to provide health insurance coverage under this Act to its employees;

(B) is not offering other comprehensive health insurance coverage to such employees; and

(C) agrees to provide the employer contribution as required under section 6(a).

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(c) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of subsection (b)(2):

(1) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which

was not in existence for the full year prior to the date on which the employer applies to participate, the determination of whether such employer meets the requirements of subsection (b)(2) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the employer's first full year.

(3) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(d) WAIVER AND CONTINUATION OF PARTICIPATION.—

(1) WAIVER.—The Office may waive the limitations relating to the size of an employer which may participate in the health insurance program established under this Act on a case by case basis if the Office determines that such employer makes a compelling case for such a waiver. In making determinations under this paragraph, the Office may consider the effects of the employment of temporary and seasonal workers and other factors.

(2) CONTINUATION OF PARTICIPATION.—An employer participating in the program under this Act that experiences an increase in the number of employees so that such employer has in excess of

100 employees, may not be excluded from participation solely as a result of such increase in employees.

SEC. 3. NATIONAL SMALL EMPLOYER AND INDIVIDUALS RISK POOL.

(a) ESTABLISHMENT.—The Secretary, in consultation with the Director of the Office, shall established a national program to make quality, affordable health insurance available to small employers and self-employed individuals in a manner that will spread risk on a national basis. The program shall be modeled on the Federal employees health benefit program under chapter 89 of title 5, United States Code.

(b) CONTRACT FOR ADMINISTRATION.—

(1) IN GENERAL.—The Secretary, in consultation with the Director of the Office, shall enter into a contract with an eligible entity for the administration of the program established under subsection (a).

(2) ELIGIBLE ENTITY.—The program under subsection (a) shall be administered by a private entity under a contract entered into with the Department of Health and Human Services. An entity shall be eligible to enter into such contract if such entity—

(A) is a medicare fiscal intermediary, a health insurance issuer, a health care provider

organization, a third party administrator, or any other entity determined appropriate by the Secretary; and

(B) can demonstrate the ability to administer the insurance program under this Act, for a population significantly larger than that populations served under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

(c) LIMITATIONS.—In no event shall the enactment of this Act result in—

(1) any increase in the level of individual or Federal Government contributions required under chapter 89 of title 5, United States Code, including copayments or deductibles;

(2) any decrease in the types of benefits offered under such chapter 89; or

(3) any other change that would adversely affect the coverage afforded under such chapter 89 to employees and annuitants and members of family under that chapter.

SEC. 4. CONTRACT REQUIREMENT.

(a) IN GENERAL.—The Administrator may enter into contracts with qualified carriers offering health benefits plans of the type described in section 8903 or 8903a of

title 5, United States Code, without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to provide health insurance coverage to employees of participating employers and individuals under this Act. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Administrator shall ensure that health benefits coverage is provided for individuals only, individuals with one or more children, married individuals without children, and married individuals with one or more children. As a condition of entering into such a contract, a qualified carrier shall agree to pay the monthly assessment required under section 11(c).

(b) ELIGIBILITY.—A carrier shall be eligible to enter into a contract under subsection (a) if such carrier—

(1) is licensed to offer health benefits plan coverage in each State in which the plan is offered; and

(2) meets such other requirements as determined appropriate by the Secretary.

(c) BENEFITS.—

(1) PILOT PROGRAM.—

(A) IN GENERAL.—The Administrator shall establish a pilot program to provide for

the offering, by carriers, of a model health benefits plan that is developed using the model provided for under section 8(c)(1).

(B) ASSESSMENT.—Not later than 5 years after the date on which the pilot program is established under subparagraph (A), the Administrator shall contract with the Institute of Medicine for the conduct of an assessment on the impact of the pilot program on health care coverage costs and access.

(2) STATEMENT OF BENEFITS.—Each contract under this Act shall contain a detailed statement of benefits offered and shall include information concerning such maximums, limitations, exclusions, and other definitions of benefits as the Administrator considers necessary or desirable.

(3) ENSURING A RANGE OF PLANS.—The Administrator shall ensure that a range of health benefits plans are available to participating employers under this Act.

(d) STANDARDS.—The minimum standards prescribed for health benefits plans under section 8902(e) of title 5, United States Code, and for carriers offering plans, shall apply to plans and carriers under this Act. Approval of a plan may be withdrawn by the Administrator only

after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

(e) CONVERSION.—

(1) IN GENERAL.—A contract may not be made or a plan approved under this section if the carrier under such contract or plan does not offer to each enrollee whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which the individual may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An enrollee who exercises this option shall pay the full periodic charges of the nongroup contract.

(2) NONCANCELLABLE.—The benefits and coverage made available under paragraph (1) may not be canceled by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(f) REQUIREMENT OF PAYMENT FOR OR PROVISION OF HEALTH SERVICE.—Each contract entered into under this Act shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Administrator finds that the employee, annuitant, family member, former spouse, or person having continued

coverage under section 8905a of title 5, United States Code, is entitled thereto under the terms of the contract.

SEC. 5. ELIGIBILITY.

An individual shall be eligible to enroll in a plan under this Act if such individual—

(1) is an employee of a small employer described in section 2(b)(2), or is a self employed individual as defined in section 401(c)(1)(B) of the Internal Revenue Code of 1986, that elects to provide coverage for its employees under this Act; or

(2) is not otherwise enrolled or eligible for enrollment or coverage of the type described in section 2701(c)(1) of the Public Health Service Act.

SEC. 6. APPLICATION OF PROVISIONS.

(a) FEHBP.—Except as provided in this section, the provisions of chapter 89 of title 5, United States Code, relating to employer contributions for coverage, requirements for rating, guaranteed issue and renewability, and other provisions determined appropriate by the Secretary (in consultation with the Director of the Office) shall apply with respect to health coverage provided under this Act.

(b) RATING AND LOSS-RATIO.—

(1) RATING.—With respect to the determination of premium amounts for health benefits plans

under this Act, the only rating factor permitted shall be an age-related factor.

(2) LOSS-RATIO.—A qualified carrier shall ensure that the loss-ratio of any health benefits plan offered by such carrier under this Act not be less than 85 percent with respect to the amount of premiums expended for patient care.

(c) CONTINUED APPLICABILITY OF STATE LAW.—

(1) HEALTH INSURANCE OR PLANS.—

(A) PLANS.—With respect to a contract entered into under this Act under which a carrier will offer health benefits plan coverage, State mandated benefit laws in effect in the State in which the plan is offered shall continue to apply.

(B) RATING RULES.—The rating and other requirements described in subsections (a) and (b) shall supercede State rating rules for qualified plans under this Act.

(2) LIMITATION.—Nothing in this subsection shall be construed to preempt—

(A) any State or local law or regulation except those laws and regulations described in subparagraph (B) of paragraph (1);

(B) any State grievance, claims, and appeals procedure law, except to the extent that such law is preempted under section 514 of the Employee Retirement Income Security Act of 1974; and

(C) State network adequacy laws.

SEC. 7. EMPLOYER PARTICIPATION.

(a) REGULATIONS.—The Secretary, in consultation with the Director of the Office, shall prescribe regulations providing for employer participation under this Act, including the offering of health benefits plans under this Act to employees.

(b) ENROLLMENT AND OFFERING OF OTHER COVERAGE.—

(1) ENROLLMENT.—A participating employer shall ensure that each eligible employee has an opportunity to enroll in a plan under this Act.

(2) PROHIBITION ON OFFERING OTHER COMPREHENSIVE HEALTH BENEFIT COVERAGE.—A participating employer may not offer a health insurance plan providing comprehensive health benefits coverage to employees participating in the program under this Act other than a health benefits plan that—

(A) meets the requirements described in section 4(a); and

(B) is offered only through the enrollment process established by the Administrator under section 3.

(3) OFFER OF SUPPLEMENTAL COVERAGE OPTIONS.—

(A) IN GENERAL.—A participating employer may offer supplementary coverage options to employees.

(B) DEFINITION.—In subparagraph (A), the term ''supplementary coverage'' means benefits described as ''excepted benefits'' under section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

SEC. 8. NATIONAL HEALTH COVERAGE COMMISSION.

(a) ESTABLISHMENT.—There is established a commission to be known as the ''National Health Coverage Commission'' to carry out the duties activities described in subsection (c).

(b) COMPOSITION.—

(1) APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the President, after consultation with and recommendations from the Institute of Medicine of the National

Academy of Sciences, from among representatives of employers, employees, health care providers, health services researchers, economists, and other health care stakeholders and experts determined appropriate by the Institute of Medicine.

(2) CHAIRPERSON, VICE-CHAIRPERSON, AND MEETINGS.—Not later than 30 days after the date on which all members of the Commission are appointed under paragraph (1), such members shall meet to elect a Chairperson and Vice Chairperson from among such members and shall determine a schedule of Commission meetings.

(3) TERMS, VACANCIES, AND QUORUM.—

(A) TERMS.—An individual appointed under paragraph (1) shall serve a term of 3 years.

(B) VACANCY.—Any vacancy in the Commission shall not affect its powers and shall be filled in the same manner in which the original appointment was made.

(C) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(c) DUTIES AND ACTIVITIES.—The Commission shall—

(1) develop a model that ensures adequate coverage for medically necessary services, promotes disease and chronic disease management, provides incentives for health provider compliance with best practices protocols, and that does not discriminate against individuals based on the nature of their medically necessary condition, but provides appropriate coverage limits based on scientifically-determined models of care;

(2) as part of the model under paragraph (1), establish a standardized benefit package for health benefit plans provided under contracts entered into under this Act;

(3) develop model cost sharing mechanisms that do not discriminate and that accommodate lower income individuals;

(4) establish a systematic means of ensuring that the health care system adopts best practices;

(5) provide for the establishment of a partnership between health care providers, manufacturers of health products, health care economists, and policy experts in the areas of health financing and delivery, to—

(A) develop a systematic means of ensuring that the health care system adopts best practices;

(B) develop procedures to combat price gouging by the manufacturers of new health products; and

(C) determine cost sharing mechanisms that do not discriminate and that accommodate low income individuals; and

(6) carry out any other activities determined appropriate by the Secretary to assist in carrying out this Act.

(d) POWERS OF COMMISSION.—

(1) HEARINGS.—The Commission may hold such hearings, meet and act at such times and places, and receive such evidence as may be necessary to carry out the functions of the Commission.

(2) INFORMATION FROM FEDERAL AGENCIES.—

(A) IN GENERAL.—The Commission may access, to the extent authorized by law, from any executive department, bureau, agency, board, commission, office, independent establishment, or instrumentality of the Federal Government such information, suggestions, esti-

mates, and statistics as the Commission considers necessary to carry out this Act.

(B) PROVISION OF INFORMATION.—On written request of the Chairperson of the Commission, each department, bureau, agency, board, commission, office, independent establishment, or instrumentality shall, to the extent authorized by law, provide the requested information to the Commission.

(C) RECEIPT, HANDLING, STORAGE, AND DISSEMINATION.—Information shall only be received, handled, stored, and disseminated by members of the Commission and its staff consistent with all applicable statutes, regulations, and Executive orders.

(3) ASSISTANCE FROM FEDERAL AGENCIES.—

(A) GENERAL SERVICES ADMINISTRATION.—On request of the Chairperson of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, administrative support and other assistance necessary for the Commission to carry out its duties.

(B) OTHER DEPARTMENTS AND AGENCIES.—In addition to the assistance provided

for under subparagraph (A), departments and agencies of the United States may provide to the Commission such assistance as they may determine advisable and as authorized by law.

(4) CONTRACTING.—The Commission may enter into contracts to enable the Commission to discharge its duties under this Act.

(5) DONATIONS.—The Commission may accept, use, and dispose of donations of services or property.

(6) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as a department or agency of the United States.

(e) STAFF OF COMMISSION.—

(1) IN GENERAL.—The Chairperson of the Commission, in consultation with the Vice Chairperson, in accordance with rules agreed upon by the Commission, may appoint and fix the compensation of a staff director and such other personnel as may be necessary to enable the Commission to carry out its functions, in accordance with the provisions of title 5, United States Code, except that no rate of pay fixed under this subsection may exceed the equivalent of that payable for a position at level V

of the Executive Schedule under section 5316 of title 5, United States Code.

(2) STAFF OF FEDERAL AGENCIES.—Upon request of the Chairperson of the Commission, the head of any executive department, bureau, agency, board, commission, office, independent establishment, or instrumentality of the Federal Government may detail, without reimbursement, any of its personnel to the Commission to assist it in carrying out its duties under this Act. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(3) CONSULTANT SERVICES.—The Commission is authorized to procure the services of experts and consultants in accordance with section 3109 of title 5, United States Code, but at rates not to exceed the daily rate paid a person occupying a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(f) REPORT AND TERMINATION.—

(1) REPORT.—Not later than 3 years after the date on which all of the members of the Commission are appointed under subsection (b), the Commission shall submit to the appropriate committees of Congress a report concerning the activities of the Com-

mission which shall include recommendations for coverage and benefits under the program under this Act.

(2) TERMINATION.—The Commission shall terminate on the date on which the report is submitted under paragraph (1).

SEC. 9. PUBLIC EDUCATION CAMPAIGN.

(a) IN GENERAL.—In carrying out this Act, the Secretary, in consultation with the Director of the Office, shall develop, and the Administrator shall implement, an educational campaign to provide information to employers and the general public concerning the health insurance program developed under this Act.

(b) ANNUAL PROGRESS REPORTS.—Not later than 1 year and 2 years after the implementation of the campaign under subsection (a), the Administrator shall submit to the appropriate committees of Congress a report that describes the activities of the Administrator under subsection (a), including a determination by the Administrator of the percentage of employers with knowledge of the health benefits programs provided for under this Act.

(c) PUBLIC EDUCATION CAMPAIGN.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2009 and 2010.

SEC. 10. TRANSITION PERIOD.

During the period prior to the date on which assessments begin under section 11(c), the Administrator shall adjust the annual premium amount assessed for coverage under a health benefits plan to reflect the median premium amount that is assessed for coverage under the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code for the year involved.

SEC. 11. REINSURANCE PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish a program to provide reinsurance to qualified carriers offering health benefit plans under this Act.

(b) AMOUNT OF REINSURANCE PAYMENTS.—

(1) IN GENERAL.—Under the program established under subsection (a), the Secretary shall, using amounts in the trust fund established under subsection (d), pay to a qualified carrier an amount determined under paragraph (2) for each large claim paid by such carrier under a health benefits plan under this Act.

(2) PAYMENT.—The amount of a payment under paragraph (1) shall be equal to 90 percent of

the amount of the large claim paid by the carrier under this Act.

(3) LARGE CLAIM.—In this subsection, the term ''large claim'' means a claim paid by a qualified carrier on behalf of a enrollee under a health benefits plan under this Act that is excess of $5,000, but less than $75,000.

(4) ANNUAL PAYMENT.—The Secretary shall develop procedures to provide for the annual payment of amounts to qualified carriers under the program under this section.

(c) ASSESSMENTS.—

(1) IN GENERAL.—The Secretary shall require the payment of monthly assessments by each health insurance issuer offering health insurance coverage.

(2) AMOUNT OF ASSESSMENT.—

(A) ESTABLISHMENT OF BASE AMOUNT BY SECRETARY.—Not later than 1 year after the date of enactment of this Act, the Secretary shall determine the base amount of the assessment under paragraph (1).

(B) AMOUNT PER CARRIER.—With respect to a health insurance issuer, the amount of the monthly assessment under this subsection shall be the product of the base amount under sub-

paragraph (A) and the number of lives covered under the health benefits plans offered by the issuer during the month involved.

(d) TRUST FUND.—

(1) ESTABLISHMENT.—There is established in the Treasury of the Untied States a trust fund to be known as the ''Small Business Health Coverage Trust Fund'', consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this subsection.

(2) TRANSFERS TO TRUST FUND.—There are hereby appropriated to the Small Business Health Coverage Trust Fund amounts equivalent to the net revenues received in the Treasury from the assessments paid under subsection (c).

SEC. 12. APPROPRIATIONS.

There are authorized to be appropriated, such sums as may be necessary in each fiscal year for the development and administration of the program under this Act.

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